

FILED SEP 14 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26492

3801

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>3801</u>	
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Jackson			
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. LENGTH OF STAY (in this place) 11 yrs.		c. CITY OR TOWN Kansas City		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital				STREET ADDRESS (If rural, give location) 433 3022 Campbell			
3. NAME OF DECEASED (Type or Print) a. (First) OLIMPIA		b. (Middle)		c. (Last) SOLIGO		4. DATE OF DEATH (Month) (Day) (Year) Aug 28, 1955	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH April 9, 1879		9. AGE (In years last birthday) 76 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (City and State or Foreign Country) Asolo, Italy		12. CITIZEN OF WHAT COUNTRY? Italy	
13a. FATHER'S NAME Louis Zamattia		13b. MOTHER'S MAIDEN NAME Catherine (unknown)		14. NAME OF HUSBAND OR WIFE James Soligo			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Frank Supancio 3022 Campbell			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myo Cardial infarction ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Intestinal Obstruction DUE TO (c) Gall Stone Cholecyst duodenal fistula II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 24-48 hrs 584 h	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1945</u> , 19 <u> </u> , to <u>8/28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/28</u> , 19 <u>55</u> , and that death occurred at <u>6 A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE J. J. Cochrane (Degree or title) MD		23b. ADDRESS 315 Nichols Rd		23c. DATE SIGNED 8/29/55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8-30-55		24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		24d. LOCATION (City, town, or county) (State) Kansas City, Mo.	
DATE REC'D BY LOCAL REG. 8-29-55		REGISTRAR'S SIGNATURE Reva Marshall		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Melody-McGilley-Eylar Kansas City, Mo.			

(Licensed Embalmer's Statement on Reverse Side)

J. J. Cochrane
Physician
9615 Grandview Rd
1:30 - 500 507140
- 403150

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision..

Student
Signature of Student Embalmer

Signed *James E. Ketchum*

Licensed Embalmer No. *457*

P. O. Address *H. C. 94*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.